Testimony of Elizabeth M. Duke
Administrator, Health Resources and Services Administration
Before the Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
"A Review of Community Health Centers: Issues and Opportunities"
May 25, 2005

Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to meet with you today on behalf of the Health Resources and Services Administration (HRSA) to discuss the Health Centers Program.

I am so pleased to have the opportunity to address you regarding the Health Centers program. I was here before the Health Subcommittee of the Energy and Commerce Committee on August 1, 2001, to discuss the reauthorization of this program. At that time, the funding for the program was approximately $1.2 billion. We thank you for both your efforts in reauthorizing the program and ensuring funding to expand this worthwhile program to accomplish the President's Initiatives, with a requested FY2006 funding level of approximately $2 billion**,** a $304 million increase.

Today, I am proud to update you on the success and growth of the program to date. By any measure, we have been enormously successful implementing the President's Health Center Expansion initiative - an effort designed to establish or expand 1,200 health center sites and serve
an additional 6.1 million patients annually by the end of 2006. This continues to be a priority because we know that 100 percent of these funds go to provide direct health care services for our neighbors who are most in need.

In 2004, the health center system served an estimated 13.2 million people - about 3 million more than in 2001- at more than 3,650 service delivery sites which represents an increase of more than 600 new and expanded sites since 2001. In 2005, we plan to fund 153 new or expanded health center sites and serve almost 14 million patients.

The President's FY 2006 budget request includes an additional $277 million to complete the President's five-year Health Centers Initiative by increasing the number of health center sites by 275 and significantly expanding 303 existing sites to increase the number of people served by 2.4 million, above 2005 levels, for a total of more than 16.3 million patients.

The President has set a new goal to open a health center or rural health clinic in every poor county that can support one. The Budget includes $26 million to open new health center sites in 40 of the Nation's poorest counties and will support 25 planning grants as well. The goal of the initiative is to leverage the success of the current program to poor counties that can support a Health Center and provide access to primary and preventive health care services particularly in poor communities that are medically underserved.

Health Centers Program

The distinguishing mission of the Health Centers Program is to empower communities to solve their own local access problems and to improve the health status of their underserved and

vulnerable populations by building community-based primary care capacity and by offering case management, home visiting, outreach, and other enabling services. The program also addresses significant challenges facing communities by targeting public housing, homeless, and migrant health center development as well. Health Centers provide access to high quality, family oriented, comprehensive primary and preventive health care, regardless of ability to pay.

Health Center grantees, as a result of their receiving from HRSA a grant under section 330 of the Public Health Service (PHS) Act, are eligible for enhanced benefits including Medicaid/Medicare reimbursement, access to the Federal Tort Claims Act (FTCA) program for malpractice coverage and access to the program for discount drugs for patients under section 340B of the PHS Act.

Under the section 330, a Health Center is required to provide primary health services, including those related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology, that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives. Additional required basic health services include diagnostic laboratory and radiologic services and a series of preventive health services, including prenatal and perinatal services; appropriate cancer screening; well-child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels; communicable diseases and cholesterol; pediatric eye, ear, and dental screenings; voluntary family planning services; and preventive dental services.

Health Centers Requirements

To receive section 330 grant funds, a clinic must meet a number of statutory requirements. The Health Center must: be located in a Federally designated medically underserved area (MUA) or serve a Federally designated medically underserved population (MUP); be a public or private nonprofit health center; provide comprehensive primary health services, referrals, and other services needed to facilitate access to care, such as case management, translation, and transportation; have a governing board, the majority of whose members are patients of the Health Center; provide services to all in the service area regardless of ability to pay; and offer a sliding fee schedule that adjusts according to individual family income.

The requirement that a majority of board members be Health Center patients makes these clinics unique among safety net providers and is designed to ensure that the centers remain responsive to community needs. Under section 330, a Health Center applicant needs to demonstrate the establishment of a governing board that has a 51 percent consumer majority, meets monthly, selects the Health Center's services and hours, approves the Health Center's annual budget, selects the Health Center's director, and establishes the Health Center's general policies.

Health Centers are located in all 50 States, the District of Columbia, and the territories. Currently the Health Center urban-to-rural ratio is even.

Health Centers Awards Process

HRSA accepts, on a competitive basis, applications from eligible organizations seeking a grant for
operational support for new and continuing Health Centers. Eligible organizations are public or nonprofit entities including tribal, faith-based and community-based organizations.

The largest category of grant awards includes new access points encompassing both new clinic starts and satellites of existing clinics. Other categories include the expansion of medical capacity at existing locations and new service expansion activities such as enhanced oral health and mental health/substance abuse services.

All eligible and responsive grant applications are referred to an Objective Review Committee (ORC), comprised of experts in the delivery of community health care services, for their independent review and recommendations. When funding decisions are made, each applicant receives a notification letter listing strengths and weaknesses of each section of their application as noted by the ORC. This review approach provides valuable technical assistance for improving future applications for both awardees and those we were not able to approve during a particular cycle due to funding limitations. The process is very competitive and during many cycles, we are able to fund only 20% of the applications submitted. This result reflects a very dynamic program which is encouraging the development of community-based primary health care clinics at a rate greater than we can provide monetary support.

Technical Assistance

HRSA works directly with communities to develop needed resources through the primary care associations in each State. These primary care associations, funded by HRSA, provide ongoing technical assistance involving guidance and options for organizations interested in applying for Health Center grants and to existing Health Center grantees interested in expanding their comprehensive primary care services.

In addition, HRSA assists applicants through grant-writing workshops and other technical assistance activities, which are provided through a contract with the National Association of Community Health Centers. Such activities assist applicants to: demonstrate a high level of need in the community; present a sound proposal to meet this need; show that the organization is ready to rapidly implement the proposal; display responsiveness to the health care environment in the service area; and demonstrate collaborative and coordinated delivery systems for the provision of health care to the underserved in their communities.

Federally-funded health centers are similar to other health care businesses. Like most businesses, at any point in time, approximately 4% of health centers are experiencing significant challenges to their viability. HRSA, with assistance from interdisciplinary teams that may include contractors, grantees and staff, provides intensive technical assistance to grantees to address problems. At all times, continuity of service for the affected population is the first priority under

consideration in addressing such challenges.

Health Centers Services

Health Centers offer ambulatory services that reflect the diverse needs of the populations they serve. Because of the combination of low incomes, linguistic barriers, and often poor health status, Health Center patients require access to enabling services as well as comprehensive primary care services.

Health Centers are unique among primary care providers for the array of enabling services they offer, including case management, translation, transportation, outreach, eligibility assistance, and health education. Health Centers commit significant resources to managing chronic conditions including diabetes, asthma, and cardiovascular disease.

In 2003, Health Centers provided more than 49 million encounters, 220,000 mammograms, over 1.4 million pap tests, and 2.27 million encounters for immunizations, as well as nearly 400,000 HIV tests and counseling, perinatal and delivery care for 332,000 women, and translation services to more than 3.5 million patients.

Health Centers are staffed by a combination of clinical, enabling, and administrative personnel. They are typically managed by a chief executive officer and a clinical director. Depending on the size of the patient population, the clinical staff consists of a mixture of primary care

physicians, nurse practitioners, physician assistants, substance abuse and mental health specialists, dentists, hygienists, and other health professionals.

Health Centers Financing

Health Centers receive funding from a variety of sources. A majority of Health Centers revenue comes from Federal resources including Medicaid, Medicare, the 330 grant, SCHIP and other Federal programs. On average nationwide, HRSA grants comprise 22 percent of Health Center revenue, but as little as 15 percent depending on the individual community and grant application. At 36 percent, Medicaid is the largest source of revenue for Health Centers, followed by Federal grants. Health Centers serve about 10 percent of all Medicaid enrollees nationally, but in actual Medicaid dollars, this amounts to less than 1 percent of all Medicaid payments to all providers.

For Health Centers' revenues, in addition to Medicaid and the section 330 Federal grant funding, Medicare accounts for 6 percent, self-pay for 6 percent, other third-party payers 9 percent, other State/local government or foundations account for 13 percent and the remaining 6 percent from other sources.

Health Centers Background

The Consolidated Health Centers program has developed over 40 years ago, beginning with the creation of the migrant health center program and followed by the neighborhood health center

demonstration projects initiated in 1965 and first funded by Congress as part of the War on Poverty. By the early 1970s, about 100 neighborhood health centers had been established under the Economic Opportunity Act. These centers were designed to provide accessible, dignified personal health services to low-income families. Community and consumer participation in the organization and a patient-majority governing board were features of the Health Center model. With the phase-out of the Office of Economic Opportunity in the early 1970s, the centers supported under this authority were transferred to the Public Health Service. The mandate of the centers was broadened so that comprehensive primary and preventive services were provided to all who came through the doors. The Community Health Center program, as authorized under section 330 of the Public Health Service Act, was established in 1975. A reauthorization that consolidated the separate authorities of the Community, Migrant, Homeless and Public Housing Health Centers under section 330 took place in 1996. Most recently, the Health Care Safety Net Amendments of 2002 reauthorized the Consolidated Health Centers Program through 2006. The 2002 Health Center reauthorization requires that grants be awarded for FY 2002 and beyond in such a way that maintains the proportion of the total appropriation awarded to migrant, homeless and public housing applicants in FY 2001. In general, about 81 percent of funding is awarded to community health centers, with the remaining 19 percent divided across migrant, public housing, and homeless health centers.

Conclusion

Health Centers offer high quality, prevention-oriented, case-managed, family-focused primary

care services that result in appropriate and cost-effective use of ambulatory, specialty and in-patient services. Primary care is delivered for all life cycles, and includes a full range of health services. In administering grants for the Health Centers program, we take great pride in the high evaluation given the program, and the bipartisan support of Congress, and fully realize that the program works only as a partnership with those extraordinary local primary care providers providing indispensable quality clinical services to underserved Americans with few health care alternatives.